



Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth



MassHealth
All Provider Bulletin 201
February 2010

TO: All Providers Participating in MassHealth
FROM: Terry Dougherty, Medicaid Director
RE: New Carrier Code Request Form



Background

A provider can now use the attached carrier code request form to report a commercial health insurance carrier that is not currently on the carrier code list in Appendix C of every MassHealth provider manual. The Third Party Carrier Code Request form is located on the MassHealth Web site at www.mass.gov/masshealth. Click on the link for MassHealth Provider Forms in the lower-right corner of the home page.

The completed form should be faxed to 617-886-8134. You will receive a fax notification once your request has been processed. The new carrier code will be available for use in NewMMIS immediately, so MassHealth can update a member's file with any update request that is received for the new carrier. The new carrier code will be seen on the carrier code list in Appendix C the next time Appendix C is updated.

Please Note: This form should be used for its intended purpose only. It should not be used for any other MassHealth or Third Party Liability (TPL) Unit communications.

Providers should continue to use the Third Party Liability Indicator form to report any changes to a MassHealth member's third-party liability. You should continue to fax these forms to the TPL Unit using the fax number at the bottom of the form.

Questions

If you have any questions about the information in this bulletin, please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.



Third Party Carrier Code Request

Date: _____

1. Commercial Carrier Information

Insurance Company Name: _____

Insurance Company Phone No.: _____

Insurance Company Address: _____

2. Policyholder and Family Information

Policyholder's Name: _____

SSN: _____ Date of Birth: _____

Policy No.: _____ Group No.: _____

Policy Start Date: _____ Policy End Date: _____

Family Members Covered:

Name: _____ MassHealth ID No.: _____

Name: _____ MassHealth ID No.: _____

Name: _____ MassHealth ID No.: _____

Name: _____ MassHealth ID No.: _____

3. Provider Information

Provider Name: _____

Contact Person: _____

Contact Phone No.: _____

Contact Fax No.: _____

Please fax this form to:

617-886-8134

Assistant Manager

Revenue Operations Benefit Coordination